New Jersey Department of Health and Senior Services
New Jersey Medicaid Program
Title XIX (Medicaid)

NOTIFICATION OF THE PROVISION OF PHARMACEUTICAL SERVICES IN A NURSING FACILITY

_____
(Name of Servicing Pharmacy)

_____
(Medicaid Provider Number)

PROVIDER AGREES:

1. To comply with State and Federal laws and regulations when providing pharmaceutical services to:

_____
(Name of Nursing Facility)

_____
(Nursing Facility Medicaid Provider Number)

2. It shall be the responsibility of the servicing pharmacy to notify the New Jersey Department of Health and Senior Services, hereinafter referred to as the Department, of any change in status regarding the provision of the pharmaceutical services described to avoid improper capitation payments.

3. The pharmacy or nursing facility identified by this notification shall provide the Department with the information requested below:

   i) A copy of a fully executed agreement between the servicing pharmacy provider and the nursing facility.

   ii) The effective date of initiating a new or changed pharmaceutical service to:

_____
(Name of Nursing Facility)

is _____
(Date)

PARTICIPATION AGREEMENT FOR THE PROVISION OF PHARMACEUTICAL SERVICES IN NURSING FACILITIES, Continued

Name of Servicing Pharmacy	Provider Number

iii) Level of Service to be provided: (Select One)

- ☐ (01) Twenty-Four (24) Hour Unit Dose Services
- ☐ (02) Modified Unit Dose Services (i.e., Bingo, Atromick; 30 day supply)
- ☐ (03) Traditional Services (i.e., drug vial dispensing)
- ☐ (04) Twenty-Four (24) Hour Unit Dose Services and Ancillary Computerized Services
- ☐ (05) Modified Unit Dose Services and Ancillary Computerized Services
- ☐ (06) Traditional Services and Ancillary Computerized Services

Note: Ancillary computerized services, if provided, shall include, but not be limited to, continuously updated computerized patient profile records, medication sheets, treatment sheets and physician order sheets which must be supplied to the nursing facility at least monthly.

This document must be returned by mail to:

New Jersey Department of Health and Senior Services
Provider Enrollment Unit
PO Box 367
Trenton, NJ 08625-0367

_____
[Name of Authorized Representative of Pharmacy (Print)]

_____
(Title)

_____ _____
(Date) (Signature of Authorized Representative of Pharmacy)

_____
[Name of Authorized Representative of Facility (Print)]

_____
(Title)

_____ _____
(Date) (Signature of Authorized Representative of Facility)

_____
[Name of Authorized Representative of NJDHSS (Print)]

_____
(Title)

_____ _____
(Date) (Signature of Authorized Representative of NJDHSS)